MIDWIVES QUARTERLY REPORT

GENERAL INSTRUCTIONS:

1. Quarterly reports are to be submitted to the Department of Health and Environmental Control by each licensed midwife.

2. Reports submitted by apprentice midwives are to be signed by the supervising M.D., C.N.M., or Licensed Midwife.

3. All information is to be recorded in black ink or typed.

4. Please make sure that your name is printed or typed in the place provided on each page and that you date each form on the day you complete it.

5. Please complete the record of each delivery or transfer at the time of the delivery or transfer. You are advised to keep your own duplicate record since the reports will remain on file at the Department of Health and Environmental Control.

6. Dates for submission will be as follows:

QUARTER	MAIL NO LATER THAN	DUE AT DHEC
January 1 – March 31	April 15	April 30
April 1 – June 30	July 15	July 31
July 1 – September 30	October 15	October 31
October 1 – December 31	January 15	January 31

7. Mail to:

   Division of Health Licensing
   South Carolina Department of Health and Environmental Control
   2600 Bull Street
   Columbia, SC 29201

8. If you need more forms or have any questions regarding these reports, access:
   http://www.scdhec.gov/hr

9. All information included on these reports will be treated as confidential.

SPECIFIC INSTRUCTIONS:

1. Summary Sheet: Midwives are to complete one summary sheet for the entire quarterly caseload. This then will be submitted along with the individual data sheets prepared for each woman in your care.

2. Individual Data Sheets:

   a. Individual data sheets are to be submitted for all women who deliver in South Carolina. It is recommended that each midwife submit individual data sheets on all women in his/her caseload so as to establish a practice record with this Division.

   b. An individual data sheet is to be completed for each woman transferred out or delivered during the quarter.

   c. The midwife who makes the transfer or attends the birth is to complete the data sheet.

      (1) For antepartum transfers – complete information to date of transfer is required; follow-up data, if available, would be helpful.

      (2) For intrapartum transfers – complete information to time of transfer is required; through the fifth day postpartum on mother and baby is preferred. If this information is not available to you, please explain.

      (3) For births – complete information through the fifth day postpartum on mother and baby is required.

   d. Section A:

      (1) Client/Birth #: Any number assigned by the midwife so that he/she can locate the record to answer or clarify questions regarding the report.

      (2) Parity: Includes the current pregnancy but not the current birth.

      (3) Antepartum Record: Gestation at 1st visit means first visit with you, the midwife; for lab tests which are repeated and may change, record initial results and most recent.

   e. Section B: Code C – consultation; T- transfer; A- admitted as appropriate. Codes may be used more than once per condition and more than one code may be used per condition. Please date if transferred out or admitted.

      Sample: Jaundice: C, C, T, A, 8/10/06.

      For Maternal/Fetal Conditions also code AP (antepartum), IP (intrapartum), PP (postpartum) as appropriate.

      Sample: Elevated temperature: IPC, PPC.

MIDWIVES QUARTERLY REPORT

SUMMARY SHEET

Name of Midwife _____ License # _____

Address: _____
(Street) (City) (State) (Zip)

Telephone # _____ Reporting quarter: _____ to _____

Number of undelivered women registered at beginning of this quarter _____

Number of women newly registered during this quarter _____

Number of women transferred out during antepartum period this quarter _____

Number transferred for medical reasons _____

List reason(s) _____

Number transferred for other reasons _____

List reason(s) _____

Number moved or lost contact _____

Number of women delivered during this quarter _____

Number attended by midwife _____

Home _____ Clinic _____

Hospital _____ Other _____

Number transferred out intrapartum _____

Home _____ CNM _____

Clinic _____ MD _____

Hospital _____ Other _____

Other _____

Number of undelivered women registered at end of this quarter _____

Signature of Midwife _____ Date _____

MIDWIVES QUARTERLY REPORT
INDIVIDUAL DATA SHEET

NAME OF MIDWIFE: _____ DATE OF REPORT _____
LICENSE NUMBER: _____
MOTHER'S NAME: _____

A. RECORD OF CLIENT /BIRTH #:

Delivery Date: _____ Time: _____

Location (County): _____

Age of Mother: _____

EDC: _____

Parity:
- Gravida (# of pregnancies): _____
- Full term births: _____
- Premature births: _____
- Abortions: _____

Living children: _____

Antepartum Record:
- Gestation (weeks) at 1st visit: _____
- Number of AP visits: _____
- Hemoglobin/hematocrit: _____
- Total weight gain: _____
- Urinalysis: _____
- Rh: _____ Titers: _____
- Serology: _____

Labor:
- Length of stage 1: _____
- Length of stage 2: _____
- Length of stage 3: _____
- Estimated blood loss: _____

Newborn:
- Sex: _____ Weight (grams): _____
- Gestational age (weeks): _____
- APGAR score 1 min: ____ 5 min: _____
- Eye prophylaxis (type) :_____
- Head circumference: _____
- # Cord vessels: _____

Postpartum visits:
- Maternal condition – 1st visit: _____ _____
- Newborn condition – 1st visit: _____ _____
- Maternal condition – 2nd visit: _____ _____
- Newborn condition – 2nd visit: _____ _____

B. CONDITIONS REQUIRING CONSULTATION

MATERNAL/FETAL CONDTIONS: (AP, IP, PP)
- Vaginal bleeding:
  - Before delivery: _____
  - During delivery: _____
  - After delivery: >500cc or 2 cups)
- Edema face/hands: _____
- Vomiting, excessive: _____
- Headache, persistent: _____
- Visual disturbances: _____
- Elevated blood pressure: _____
- Proteinuria/Glucosuria (specify) _____
- Elevated temperature: _____
- Inadequate/Excessive wt. gain: _____
- Meconium staining: _____
- Slow/irregular Fetal heart: _____
- Unengaged head: _____
- Presentation other than vertex: _____
- Prolonged rupture of membranes: _____
- Prolonged labor:
  - First stage: _____
  - Second stage: _____
- Presenting part other than vertex: _____
- Multiple gestation: _____
- Retained placenta: _____
- Retained placental fragments or membranes: _____
- Uterine atony: _____
- Laceration, perineal/vaginal: _____

Other conditions (please specify): _____ _____

INFANT CONDTIONS
- Weight <2500 gms or >4100 gms: _____
- Congenital anomalies: _____
- APGAR <7 at 5 min.: _____
- Respiratory distress: _____
- Irregular heartbeat: _____
- Immaturity/Post maturity: _____
- No urine/stool within 12 hrs of birth: _____ _____
- Jaundice: _____
- Abnormal cry: _____
- Pale, cyanotic or gray color: _____
- Abnormal cord vessels: _____
- Other conditions (specify): _____

> More than <Less than

Code Section B as follows: C-Consultation, T-Trans. To hospital ER or MD office, A-Admitted to hospital

Name of Midwife: _____
Quarter Reported: _____ to _____

WOMEN ACCEPTED FOR CARE

INSTRUCTIONS: Report all women provided screening or consultation for your services. Make additional comments on back of form. Submit to DHEC quarterly.

PATIENT		INITIAL SCREENING			STATUS		
NAME	COUNTY OF RESIDENCE	DATE	TYPE (PHONE, VISIT)	GESTATION WEEKS	WAS PT. ACCEPTED FOR CARE (EDC)?	IF PATIENT NOT ACCEPTED STATE REASON	IF PT. NOT ACCEPTED, STATE REFERRALS TO OTHER PROVIDERS (MD, CNM, HEALTH DEPT, ETC.)

CONSUMER FEEDBACK FORM

Name of Patient _____ Date _____

Name of Primary Midwife _____

Name(s) of Apprentice Midwife(ives) _____

Baby's Name _____ Sex _____ Weight _____

Date of Delivery _____ Time _____ A.M. _____ P.M.

Place of Delivery: Own home _____ ; Another's home _____ ; Hospital _____ ;

Birthing Center _____ ; Other (please explain): _____

Type(s) of care your midwife delivered and dates that care began:

_____ Prenatal check-ups _____, 20___

_____ Delivery _____, 20___

_____ Newborn exam _____, 20___

_____ Labor management _____, 20___

_____ Post-partum check _____, 20___

Were there any complications with your pregnancy, labor, delivery, or post-partum course?

_____ No _____ Yes (If yes, please explain; attach additional paper if necessary) _____

_____

Number of times you visited a doctor or clinic for prenatal care ___. Briefly describe your experience with your midwife, to include your degree of satisfaction/dissatisfaction with the care provided:

_____

_____

List what you liked most about your midwife's services to you:

1.

2.

3.

List what improvement(s) you would suggest in your midwife's services:

1.

2.

3.

CONSUMER FEEDBACK FORM

Midwives licensed in South Carolina are asked to give a Consumer Feedback Form to each woman in their care. These forms are used by the Division of Health Licensing of DHEC to monitor needs for continuing educations.

Please complete this form in full after you have completed the care from your midwife, fold, staple or tape, and mail. If you have questions regarding the form, please ask your midwife. All information is considered confidential. Your cooperation in this matter is appreciated.

Place Stamp Here

Division of Health Licensing
S.C. Department of Health and Environmental Control
2600 Bull St.
Columbia, SC 29201
